Guide to Chapter 2

CHAPTER 2

Financial Eligibility Rules and Options[1]

Medicaid's flexibility has resulted in wide differences among states that offer them opportunities to learn from and build on one another's experiences. This chapter explains what Federal rules require, and allow, states to do that affects financial eligibility for Medicaid for persons who need assistance in paying for long-term care needs that can be met by home and community services.

Introduction

Medicaid today is a far different program from Medicaid as enacted in 1965. As originally conceived, Medicaid was to have served primarily the very poor and near poor who qualified or were close to qualifying for cash welfare. It was to have functioned much like private health insurance, with service coverage focused on acute care needs. Over time, Federal and state actions have expanded Medicaid's authority, the scope of its coverage of long-term care services, and its eligibility options for beneficiaries who are not "poor" by the traditional welfare-based definition. By the end of its first decade, Medicaid had become a major source of public funding for institutional long-term care. By the end of its third decade, it had become the major public funder of home and community long-term care services as well.

Medicaid is likely to become an even more dominant payer for persons being served in community settings in the future, because of the unique interplay of two program features. First, funding is based on an individual entitlement concept and there are no fixed or predetermined caps on a state's spending. The amount spent is a function of Federal, state, and sometimes local decisions about who is eligible, what they are eligible for, and what rates Medicaid pays for covered services to eligible beneficiaries. Second, states have enormous flexibility under Medicaid to design and tailor their home and community service systems.

Medicaid's role in financing long-term care has developed in sporadic increments—often in reaction to problems occupying center stage at a particular time. As a result of incremental policymaking combined with vast variations in how states cover long-term care, the various facets of Medicaid's financial eligibility provisions may appear to be disjointed. In particular, there are many provisions with major eligibility discontinuities—wherein a slight change in individuals' personal circumstances can result in huge differences in the kinds (and levels) of benefits they are eligible for. The purpose of this chapter is to put the relevant information together in a way that is most useful to state policymakers and advocates.

What Services Medicaid-Eligible Persons Receive

The highlights of Medicaid service coverage alternatives listed here provide a general context for the financial eligibility discussion of this chapter. (For full detail, see Chapters 4 and 5.)

- Once determined eligible for Medicaid, beneficiaries are entitled to the full range of Medicaid services covered in their state, for both their acute and long-term care needs. When long-term care services are provided through HCBS waiver programs under Section 1915(c) of the Social Security Act, or as a state plan service through the personal care option, only people specifically determined eligible for those programs can receive the services.
- Medicaid acute care coverage (e.g., hospital, physician, or prescription drug services) can be extremely important to persons who need long-term care services, especially if they do not have Medicare or private health insurance to cover those expenses.
- Medicaid services for children can be more extensive than Medicaid services for adults or than services typically covered under private insurers' well-child programs.
- Medicare and Medicaid cover many of the same services (e.g., hospital, physician, and home health services). For persons eligible for both Medicare and Medicaid, Medicaid generally pays beneficiary cost-sharing for all services covered by Medicare. Medicare beneficiaries eligible under any of their state-defined Medicaid eligibility groups typically receive Medicaid coverage of Medicare cost-sharing requirements, including premiums, deductibles, and coinsurance. They also receive Medicaid services covered by Medicaid but not Medicare. The most notable examples are prescription drugs, more extensive coverage of mental health services and long-term care institutional services, and personal care services, as well as home health services with a less intense medical orientation than services covered under the Medicare home health benefit.[2]
- States provide some long-term care services under Federal mandate. They provide others at their option, which may be provided either to all eligibles under the state's Medicaid plan or to selected groups under an HCBS waiver. Under an HCBS waiver program, states can provide services not viewed as strictly medical (e.g., homemaker or chore services and respite care).

Overview of Medicaid Financial Eligibility

Medicaid financial eligibility is deeply rooted in two Federally financed programs of cash assistance to help support low-income individuals and families: the former Aid to Families with Dependent Children (AFDC) program, which provided income support for low-income families with children, and the Supplemental Security Income (SSI) program for elderly persons, blind persons, and persons with disabilities. (In 1996, welfare reform legislation replaced AFDC with a new program, Temporary Assistance for Needy Families [TANF].)

Like AFDC/TANF and SSI, Medicaid is a means-tested entitlement. That is, anyone qualifies for Medicaid if (a) their income and assets do not exceed the state thresholds specific to their eligibility group, and (b) they meet all other relevant eligibility criteria.

Medicaid eligibility rules fall into two basic sets: categorical and financial. The categorical set defines particular categories of persons for whom Federal law permits coverage. Persons needing long-term care services generally fall into one of three Medicaid categories: persons who are age 65 or older, persons who are blind, and persons with disabilities. Medicaid criteria for determining who is blind or has disabilities are generally the same as they are for SSI, as established by the Social Security Administration. To qualify in a disability category, a person must have a long-lasting, severe, medically determinable physical or mental impairment. The person must also be unable to work—defined in 2000 in part as earning less than $700 per month (net of income-related work expenses), a level of earning considered by regulation as evidence of one's ability to engage in substantial gainful activity (SGA).

Anyone not meeting these criteria cannot receive Medicaid in a disability category of eligibility,

even if they have extensive medical needs or high medical bills. (Special exceptions—which allow Medicaid eligibility for certain former child beneficiaries of SSI disability benefits as well as for persons who do not meet one or more of the usual SSI disability criteria because they earn more than $700 per month—are discussed later in the chapter.)

Medicaid's financial eligibility rules for persons who are elderly or have disabilities are built on a foundation of SSI rules. But many exceptions and variations have been enacted over the years to make them work better for low-income persons needing health care but not cash assistance.

Basic Medicaid Eligibility Rules

- *Categorical criteria*—Eligible persons must
  - — be age 65 or older, or
  - — be blind, or
  - — have disabilities (using the same criteria as for disability in SSI).
- *Income and resources*—Eligible persons must have incomes that are low or severely reduced by medical expenses. In addition:
  - — Thresholds vary by eligibility category and family size.
  - — Some thresholds are established by Federal law, some by states within broad Federal guidelines.
  - — Thresholds must apply statewide (except under special waiver financial rules, which apply only if (a) the waiver is not statewide, and (b) there is a waiver-specified threshold).
- *Legal status, residence, and eligibility redetermination*—Eligible persons must
  - — be a citizen or in appropriate immigration status.
  - — be a resident of the state or, if not, eligible under an interstate compact.
  - — report changes in circumstances and have eligibility periodically redetermined by the state.

Medicaid for SSI Beneficiaries

SSI is the Federally administered program that ensures a nationally uniform income floor for persons who are elderly, who are blind, and who have disabilities. To be eligible, both income and assets must be low. Forty states provide Medicaid to all individuals in any month in which they receive an SSI payment. Of these, 33 do so automatically, based on a list of SSI beneficiaries compiled by the Federal Social Security Administration. The other 7 require SSI beneficiaries to file a separate application with the state for Medicaid benefits. The remaining 11 states follow what is known as the 209(b) exception option, described below, which allows them to provide Medicaid to SSI beneficiaries only if they meet the state's criteria, which may be more restrictive than those for SSI.

General Rule

The general income rule for SSI specifies the level of "countable income" at or below which a person is financially eligible for benefits. Countable income includes cash income plus certain in-kind goods or services a person receives in a given month, *minus* certain amounts that are exempt from the SSI benefit calculation (discussed more fully below). In the year 2000, the maximum monthly SSI benefit paid to persons with no other income is $512 for an individual and $774 for a couple. Persons with income from other sources (e.g., Social Security or a pension) receive a lesser amount—equal to the difference between the full SSI benefit rate and the amount of their countable income from other sources. For example, the SSI benefit for an individual with countable income of $500 would be only $12 per month.

The general rule defines countable resources as cash or other property, including real property, that (a) were acquired some time in the past, (b) the individual has the right to access, and (c) could be converted to cash and used to cover current basic living needs. Individuals with up to $2000 ($3000 for a couple) in countable resources can qualify for SSI. SSI resource limits are often used as the minimum base for resource eligibility for Medicaid.

Exceptions

There are two major exceptions to the general rule: the state 209(b) option and protection for cer-

tain former SSI beneficiaries. (Mandatory Medicaid protection for certain children with disabilities and certain working persons with disabilities is discussed later in this chapter.)

State 209(b) option

Medicaid for the "Aged, Blind, and Disabled" had historically always been linked to receipt of cash assistance benefits. When SSI replaced state-only programs of aid for elderly persons and persons with disabilities, it was expected to lead to large increases in the numbers of SSI beneficiaries. The 209(b) option was enacted along with SSI in 1972 to enable states to avoid experiencing similarly large increases in Medicaid enrollment and costs.

Many Medicaid eligibility rules in 209(b) follow SSI. But states may choose, instead, to use some or all of the more restrictive Medicaid rules in effect in their state on January 1, 1972, shortly before SSI was enacted. Typically these states have retained at least some of their pre-SSI rules on countable income or resources. Some use more stringent criteria for determining blindness or disability.

To counterbalance the potential negative effects of the 209(b) option on SSI beneficiaries, Federal rules require 209(b) states to allow any residents who are elderly, blind, or have disabilities—including those with too much income for SSI—to spend down to the state's Medicaid income standard if their expenses for medical and remedial services so erode their income that their "net" remaining income would be less than a standard set by the state. This requirement creates a medically needy-like program for this population, even in states that have not chosen specifically to cover the medically needy as an option, as in Indiana, Missouri, and Ohio. Spend-down rules for 209(b) are virtually identical to spend-down rules for the medically needy (discussed below).

Medicaid protection for certain former SSI beneficiaries

Federal law requires all states, including 209(b) states, to provide Medicaid to former SSI beneficiaries who would, but for increases in their Social Security benefits, continue to be eligible for SSI. Congress passed this provision to ensure that Social Security increases, intended to improve people's lives, did not harm this group instead by causing them to lose Medicaid as well as SSI. Most of the individuals affected have incomes just marginally above the income levels at which they might qualify for SSI/Medicaid combined benefits. In fact, many persons who could qualify for Medicaid under these provisions do not apply for the program, most likely because they are not aware of them. Improved understanding of these protections may help increase the Medicaid enrollment of this group.

Former SSI Beneficiary Groups with Medicaid Protection

- People who lost SSI when they received automatic cost-of-living adjustments (COLAs) in Social Security (sometimes nicknamed "Pickle people" after Congressman Pickle, one of the sponsors of the original COLA legislation)
- Adult children with disabilities who lose SSI because they become entitled to Social Security benefits based on a parent's Social Security entitlement
- Individuals ages 60–64 who lose SSI due to receipt of Social Security benefits for widows and widowers with disabilities

Countable Income or Resources

The concept of countable income and resources may seem arcane but is important. Neither SSI nor Medicaid determine eligibility by comparing a person's total income and resources to the dollar thresholds that apply in the person's eligibility category. Rather, they count only certain types and amounts. (This practice has a close counterpart in income tax rules, which exempt certain types or amounts of income from taxation and allow certain types or amounts to be deducted from otherwise taxable income.) For this reason, an individual can have total income or resources higher than the nominal eligibility limits (i.e., higher than $512 in total income or $2000 in total resources for SSI) and still qualify for benefits.

SSI Rules

SSI rules reduce a person's gross income to get countable income in three important ways. First, SSI disregards the first $20 of every applicant/recipient's income. Second—and of great significance to people with disabilities who work—SSI provides a disregard of earnings from work, amounting to the first $65 plus one-half of the remaining earnings amount. Third, spouses or children with disabilities in families with other members who are ineligible can qualify for SSI at higher gross amounts of family income, because SSI counts only the portion of the nondisabled spouse's or parent's income that is left *after* SSI subtracts amounts to cover the basic needs of nondisabled family members. (SSI may apply several other special-purpose reductions also.)

SSI rules reduce gross resources in determining whether resources are below the SSI $2000/$3000 thresholds, by exempting the home (regardless of value) and (within limits) such things as an auto, household goods, surrender value of life insurance, burial funds, and property essential to self-support.

Medicaid Exceptions

In general, states use SSI rules in determining what is countable income and resources for Medicaid eligibility.[3] But states have the option to liberalize their Medicaid rules of what is countable. Such disregards redefine how income or assets are countable in such a way that the eligibility limits specified in the law, while still theoretically applicable, can be greatly exceeded.

Examples of Provisions That Can Reduce Countable Income or Resources

- Allow more than the standard SSI income disregard of $20
- Disregard more earnings from work
- Disregard all or part of certain types of resources that are limited under SSI, for example, income-producing property essential to self-support, burial funds, cash value of life insurance

It is important to note that this state flexibility comes with certain restrictions. First, the different counting methods must not disadvantage anyone, even if relatively more people would benefit than would be disadvantaged. Second, although a state may restrict its more liberal counting method to eligibility groups it selects, the group(s) must be specifically defined in Medicaid law—for example, working persons with disabilities, the poverty-related groups, or the 300 percent of SSI groups (all of which are discussed more fully below). Thus, states are not permitted to carve out a subgroup of their own definition (e.g., one based on medical diagnosis or place of residence).

Third, flexibility in counting income is highly limited for medically needy eligibility groups (described below), because Federal law imposes a ceiling on medically needy income levels (133 1/3 percent of the highest amount paid to an AFDC family of the same size). States are not permitted to exceed this ceiling, which limits opportunities for states with medically needy income levels at or close to the ceiling.[4]

While Federal rules give states broad flexibility to expand eligibility, actual adoption of more generous alternative methods must, of course, conform to a state's budget considerations and political decisions.

Eligibility Expansion Options Including, but Not Specific to, Home and Community Services

Certain state Medicaid options for across-the-board eligibility expansions capture anyone who meets the criteria, including but not limited to persons needing long-term care services. Because these options cannot be targeted, they involve cost implications for states that make them unlikely candidates for a state looking for narrower home and community service expansions. States may be encouraged to adopt these wider options, however, for other excellent reasons. Persons eligible under any of these options receive the full range of acute and long-term care

services covered under the state plan, for example. In addition, if they meet the state's criteria for HCBS waiver participation (e.g., level of care, diagnosis, or place of residence) they can receive waiver services.

General Eligibility Expansion Options

- 100 percent of poverty option
  - — Allows states to provide full Medicaid benefits to all elderly persons or persons with disabilities with countable income below poverty and low resources.
- Medically needy option
  - — Allows eligibility for those who would qualify except for income.
  - — Higher income persons must spend down. And states may not cover medically needy who are elderly or have disabilities without also covering medically needy pregnant women and children.

Two Hypothetical Spend-Down Situations

Assume the state's medically needy income level for an individual is $450 per month.

- For individuals with monthly countable income of $550, the spend-down liability is $550 minus $450 (= $100), a difficult but perhaps manageable amount for a person with very high recurring medical expenses.
- For individuals with monthly countable income of $950, spend-down liability is $950 minus $450 (= $500), a manageable amount only for those with time-limited medical needs or those in nursing homes who do not need income to maintain a home and other expenses of living in the community.

100 Percent of Poverty Option

States have the option to raise the income level at which any elderly person or person with disabilities in the state can qualify for Medicaid as high as 100 percent of the Federal poverty level ($8350 for one person in calendar year 2000, increasing incrementally for additional family members). The state's eligibility limits on countable resources must be at least as high as SSI levels ($2000 for one, $3000 for a couple).[5]

It bears repeating here that what is compared to these eligibility levels is countable (not total) income and assets. At the very least, states must disregard the same kinds and amounts of income and resources that SSI disregards.

Medically Needy Option

States can cover people with too much income to qualify in any other eligibility group under the medically needy option. There is no specified ceiling on how much income a person can have and still potentially qualify if their medical bills are high enough. However, a number of caveats limit the attractiveness of the medically needy option for higher income persons needing long-term care, especially home and community services, relative to the more narrowly targeted options discussed in the next section. Caveats include the following:

- Individuals must fit into one of the Medicaid-coverable categories—for example, be age 65 or older or meet the Social Security Act criteria for disability. If not, they cannot qualify as medically needy no matter how low their incomes or how extensive their medical need.
- At a minimum, states choosing this option must first cover medically needy pregnant women and children. Most states that cover the medically needy also extend it to elderly persons or persons with disabilities.
- States may not restrict eligibility based on medical condition, type of services needed, or place of residence.
- Eligibility limits on resources are typically the same as for SSI.[6]
- States must use a single eligibility level for income and resources for all medically needy groups they elect to cover. In the case of income levels, this single level may not exceed 133 1/3 percent of the state's pre-welfare reform AFDC payment levels. Where these are very low, the

medically needy income levels may be kept to a level that is less than the SSI level.

- Medically needy persons with incomes above the state's threshold must spend down before becoming eligible for Medicaid benefits.

This last, the spend-down requirement, can be a major pitfall for higher income people who wish to qualify for home and community services through the medically needy provision. The reason is that medically needy persons with incomes above the state's Medicaid income threshold must spend down to that threshold *on a periodic basis* in order to remain eligible for Medicaid funding of the services they need.[7] Until their spend-down limit is reached, they are responsible for their own medical expenses. There is no Federal or state requirement that individuals spending down actually pay their bills. But as a practical matter, providers are unlikely to continue serving them if they fail to pay. Alternatively, states can offer people the opportunity to meet their spend-down obligation by paying it directly to the state in exchange for immediate coverage of all their medical expenses. In either case, however, persons with incomes well above the state threshold may have a spend-down liability that leaves them insufficient income to cover all their expenses at their current living standards.

Because of these limitations, spend-down works best for people in three kinds of situations: (a) they have a one-time, short-term need for assistance; (b) they are permanently in an institution and no longer need income to maintain their former lifestyle; or (c) their income is low enough to result in a spend-down liability that is affordable to them. (This is discussed further in Chapter 5.)

Eligibility Expansion Options That Can Be Targeted to Persons Needing Home and Community Services

This section discusses options states can use to apply income standards that allow persons with higher incomes to qualify—and can be targeted more narrowly to persons needing long-term care services in a variety of home and community settings.

Targetable Eligibility Expansion Options

- Provide State Supplemental Payments for special needs.
- Apply 300 percent income rule, including:
  - — Miller trusts
  - — Post-eligibility share-of-cost obligation to eligible persons.
- Ignore income or resources of ineligible spouses or parents.
- Extend spousal impoverishment protections.

State Supplemental Payments (SSPs) for Special Needs

- States can supplement the basic SSI payment.
- States can pay across-the-board SSPs to all elderly persons or persons with disabilities in the state, or they can target them to persons in supported living settings.
- States can provide Medicaid to people receiving an SSP who are not eligible for SSI.

State Supplemental Payments

Many states supplement the basic SSI level and pair these supplementary payments with automatic Medicaid eligibility. This combination of benefits enables beneficiaries to get the services they need in a variety of community settings.

The maximum monthly Federal SSI benefit ($512 in 2000) is assumed to be minimally sufficient to enable recipients to pay for a basic level of ordinary living expenses (food, shelter, clothing). Many states have elected to spend state-only, unmatched money to supplement the basic SSI rate in circumstances where they have determined that rate to be insufficient to cover living expenses necessary for minimally adequate living standards. These state supplements are state-determined and vary widely by state.[8] Some individuals have too much income to qualify for SSI but may qualify for an SSP benefit only. States can elect to make such persons automatically eligible for Medicaid, just as they can for SSI beneficiaries.

How a State Supplemental Payment (SSP) Might Work

In the year 2000, the Federal SSI monthly benefit rate is $512 for an individual. Assume a state sets its supplemental benefit at $200 (making the SSP benefit rate $712). Then,

- A person receiving Federal SSI would receive an additional SSP amount of $200 per month.
- A person with countable income of $612—from, say, Social Security or pension—would have $80 [$100 minus $20 disregard] too much income to qualify for SSI, but would still qualify for a $100 SSP benefit.

Few states provide across-the-board state supplements to SSI. Most target them specifically to persons who are unable to live entirely independently—who do not need the high level of medically oriented care provided in a nursing home or ICF/MR, but who can live comfortably in settings that provide them with some combination of non-medical assistance and non-intensive medical or related services. The additional income they receive through the state supplement can be used to pay for that additional level of service. Automatic Medicaid eligibility for state supplement beneficiaries provides an additional measure of assistance in paying for needed medical services. States have broad flexibility with respect to not only the level of SSP support but also the kinds of settings to be supported, quality standards, and oversight. States can pay SSPs for as many different types of supported living settings as they wish.

For states that restrict SSPs to persons in supported living settings, the required services vary widely. They can consist of as little as housekeeping or general supervision, or they can extend to various levels of assistance with ADLs. They can include single-family homes, group homes, adult foster care, congregate or domiciliary care, and other settings defined by the state. (The opportunities and limitations of SSI state supplements for persons in assisted living settings are discussed in greater detail in Chapter 5.)

As with many other Medicaid options, the option states have to provide Medicaid to SSP beneficiaries not eligible for SSI is subject to certain conditions. The SSP must be based on need. And the state must pay the SSP on a regular basis to anyone in the supported living setting to which the SSP applies who, but for income, would qualify for SSI. There is no rule obligating the state to establish such settings throughout the state. If the particular type of living setting supported by a state's SSP happens to exist only in limited areas of a state, the state is permitted to pay SSPs just to persons in those settings.

300 Percent of SSI Income Rule

This option was originally created so that states not wishing to cover the entire category of medically needy could at least cover higher income persons residing in a medical institution. States electing this option may establish a special income threshold, applicable to a person's gross income (all income, not just countable income), as high as 300 percent of the maximum SSI benefit. Persons who qualify based on income must also have resources within Medicaid eligibility limits. States typically use the same asset limits as SSI, but they may use more liberal Medicaid exemption rules.[9]

When originally created, the 300 percent option was limited to persons in institutions, because home and community alternatives to nursing home services were extremely limited and not much in the public view. But when home and community waiver services were enacted into law in 1981, the law allowed states to make beneficiaries of these services eligible on the same basis as persons in institutions—thus extending the 300 percent option to the home and community context.

The goal was laudable: to enable states to neutralize incentives for a person to choose nursing home over community services simply because of Medicaid eligibility rules. But the effectiveness of the 300 percent option in increasing access to home and community services is limited by two important factors. First, it can only be applied to persons receiving home and community services under a waiver program. There is no authority allowing states to use the option to expand eligibility for persons receiving such services outside a waiver program, for example, personal care serv-

Overview of the 300 Percent Income Rule

- Allows eligibility for persons with gross incomes at or below 300 percent of current SSI—$1536 in 2000.
- Allows states to use the option for persons residing in a medical institution. If they do so, states can also extend the 300 percent of income level to eligibility for HCB waiver services.
- Allows states to provide HCB waiver services to children without regard to their parents' income or assets and to married individuals without regard to their spouse's income.
- Requires states to impose a post-eligibility cost-sharing burden (discussed further below).
- When the 300 percent rule is a state's only option for providing Medicaid to higher income persons in medical institutions (i.e., the state does not have a medically needy program), allows persons to achieve eligibility by diverting excess income into a *Miller trust* (discussed below).

ices provided under the state plan. Second, individuals eligible under this option, whether in an institutional setting or under an HCBS waiver program, are subject to a post-eligibility share-of-cost obligation (described below).

Miller trusts

In states where the long-term care eligibility of higher income persons is limited to those qualifying under the 300 percent eligibility option, individuals with too much income to qualify for Medicaid long-term care services even under the 300 percent rule may still qualify by diverting their income into what is known as a Miller trust. Miller trusts are not limited to persons needing Medicaid for nursing home care or HCB waiver services. State Medicaid agencies may choose, but are not required, to play a role in helping establish these trusts.

To qualify as a Miller trust, contributions must consist solely of the individual's funds (income such as monthly Social Security or pension benefits, but not resources) and must be used solely for the benefit of the individual. There are no limits on how much income can be placed in the trust. But if amounts paid out of the trust exceed the fair market value of goods and services on behalf of the individual, then the individual may be at risk of a penalty for an uncompensated asset transfer resulting in loss of Medicaid coverage for needed services. Additionally, amounts paid out of the trust count as income—whether paid directly to the beneficiary or paid to purchase something on their behalf (other than medical care). This "income" must be under the eligibility level in the state and is subject to post-eligibility share-of-cost rules. Finally, the trust must specify that the state will receive any amounts remaining after the person's death, up to the amount the state paid in Medicaid benefits for the Miller trust owner.

Protected amounts in calculating post-eligibility share-of-cost obligation (an obligation that applies only to certain beneficiary groups)

Persons who become eligible for Medicaid under the 300 percent option, whether in a nursing home or in a waiver setting, are typically expected to pay a share of their income toward the cost of their care, which they pay providers directly.[10] This post-eligibility share-of-cost obligation can be quite high, depending on the individual's circumstances and the options the state has chosen. However, unlike nursing home care, which requires beneficiaries to contribute all but their personal needs allowance and other amounts described below, state waiver programs have greater flexibility to determine how much income a person can retain. Some states require little or no cost sharing by waiver beneficiaries. As with the medically needy spend-down provision, Federal rules do not require the individual to actually pay the share-of-cost amount. But care providers can ensure payment through their usual bill collection activities.

The share-of-cost calculation is made by subtracting from total income certain amounts that are protected for the individual's personal use. The remaining income is the individual's share-of-cost obligation. The Medicaid program reduces the amount it pays for Medicaid services by the amount the individual is expected to pay. Protected amounts include:

- Amounts to cover basic needs.

States must allow persons in nursing facilities and ICFs/MR to keep a minimum of $30 per month to cover personal needs. States also have the option to establish a higher amount across the board, or to establish higher amounts for reasonable classifications, for example, for persons receiving income from sheltered workshops.

The small size of the personal needs allowance for individuals in an institutional setting is because the institution provides for most of the individual's basic living needs, and receives Medicaid payment for these services as part of the nursing home's per diem payment rate. States establish higher allowance amounts for persons eligible under the 300 percent rule in HCBS waiver programs, because waiver participants must cover their living expenses out of pocket. A state can set the allowances for this group equal to the income eligibility thresholds that apply to other Medicaid eligibility groups in the state (e.g., at the SSI or medically needy income levels). The most generous HCBS waiver programs allow eligible individuals to retain all their income for personal use, thereby effectively eliminating any beneficiary liability for a share of cost and making Medicaid pay the entire cost of covered services. State decisions depend in part on budget concerns, because the less beneficiaries spend as share-of-cost transfers, the more the state must contribute.

- Allowance for a spouse or other dependents.

  States must deduct income to provide for a spouse of an individual in a medical institution. The amounts protected for spouses of institutionalized persons are governed by the rules designed to protect against spousal impoverishment (discussed in the next section). States must also provide for the needs of spouses of persons eligible for HCB waiver services under the 300 percent eligibility option. At a minimum, Federal regulations require states to establish what they determine to be a reasonable amount. But Federal law gives states the option to be more generous to these waiver spouses by applying spousal impoverishment rules.

- Home maintenance allowance (at state option).

  Persons eligible under the 300 percent option can retain an additional amount for up to six months if needed for maintenance of a home. In the case of institutionalized persons, this allowance is limited to those who can reasonably be expected to return to their homes.

- Amounts to cover other medical expenses.

  States must allow nursing home, ICF/MR, and HCBS waiver beneficiaries to retain enough income to pay for additional medical costs they incur that are not paid for by Medicare, Medicaid, or any other payer.

To Deem or Not to Deem—Defining the Income and Resources of a Beneficiary's "Household"

Currently, states typically follow Federal SSI rules on whether or not to count (deem) income/resources of a spouse or parent in determining a person's financial eligibility. These rules impart a substantial institutional bias by ignoring the income/resources of spouses or parents when assessing eligibility if a person is living in an institution, but counting them when the person needing long-term care services lives at home.[11]

These different deeming rules make it much more likely that a person will meet Medicaid's financial eligibility test if they live in an institution than if they live at home. Thus, families considering how to get long-term care services for a spouse or child with disabilities may find that these deeming rules leave no realistic alternative to institutionalization.

States can overcome this institutional bias by choosing not to deem the income/resources of spouses or parents available to persons eligible under an HCBS waiver program. Doing so provides access to home and community services on the same financial basis as long-term care services provided in an institutional setting. *It is important to emphasize that the option not to deem does not extend to persons living and receiving long-term care services outside the waiver context*, except with

Examples of Spousal Income Protection

Assume the minimum protection allowance ($1406) applies.

Example 1:

Beneficiary's income	$2000
Spouse's income	None
Beneficiary income protected for spouse	$1406
Beneficiary income for share-of-cost calculation	$594 ($2000 – $1406)

Example 2:

Beneficiary's income	$2000
Spouse's income	$1000
Beneficiary income protected for spouse	$406 ($1406 – $1000)
Beneficiary income for share-of-cost calculation	$1594 ($2000 – $406)

Example 3:

Beneficiary's income	$2000
Spouse's income	$2000
Beneficiary income protected for spouse	None
Beneficiary income for share-of-cost calculation	$2000

respect to children in those states that have elected the Katie Beckett or TEFRA option.[12]

Spousal Impoverishment

In 1988, Congress mandated that states allow married couples separated by the institutionalization of one spouse to protect a certain amount of assets and income for the non-institutionalized spouse. This mandate applies regardless of how the institutionalized person establishes eligibility. Prior to this law, states protected no assets, and the amounts of income they protected for the support of the at-home spouse were at welfare-like levels—a devastating event for middle-class couples facing, perhaps for the first time in their lives, a need for public assistance because of the high cost of nursing home care.

Spousal impoverishment protection is available under two circumstances: (a) residence in a nursing facility or (b) residence in the community under an HCBS waiver program. The waiver option enables states to level the playing field by protecting spousal income/assets for waiver participants to the same extent as they do for spouses of Medicaid residents in institutions.

How spousal impoverishment protection works is described here for states that wish to use it for home and community service beneficiaries under an HCBS waiver program. There are two decisions states make within the Federal limits: (a) how much *income* to protect and (b) what amount of *assets* (resources) to protect.

Income protection

Income is protected for the spouse after the person needing long-term care has been determined eligible for Medicaid. The minimum monthly protected spousal income amount is $1406 in the year beginning July 2000. Additional amounts, up to a maximum of $2103, are protected if the spouse has unusually high housing costs or if the state has chosen to protect more than the minimum amount for all spouses. If income belonging to the spouse is less than the protected level, the Medicaid beneficiary can transfer his or her own income to the spouse to make up the shortfall. States count any remaining income of the Medicaid beneficiary, less the allowance for the spouse, in calculating the share of the Medicaid service costs the beneficiary is responsible for.

Resource protection

The resource amount protected for the spouse is

Examples of Spousal Resource Protection

- The non-Medicaid spouse in a couple with combined total assets of $16,824 or less is allowed to keep the entire amount and the institutional spouse meets the assets eligibility criterion without delay.
- In a state using the Federal minimum level, couples with total countable assets of $100,000 will have $50,000 protected for the at-home spouse. The remaining $50,000 is attributed to the institutionalized spouse, making that person ineligible for Medicaid until $48,000 is used up (assuming the applicable Medicaid resource eligibility level is the typical $2000).
- In a state electing a higher minimum protected amount of, say, $75,000, couples with combined countable assets of $100,000 will have $75,000 protected for the non-Medicaid spouse. The remaining $25,000 is attributed to the institutionalized spouse, making that person ineligible until $23,000 is used up (again assuming the typical $2000 as the applicable Medicaid resource eligibility level).
- In a state protecting the highest amount allowed ($84,120), a spouse in a couple with total assets of $84,000 would keep the entire amount.

determined as part of the process of determining the Medicaid eligibility of the person needing services. Countable resources belonging to either or both members of the couple are combined and divided in half. The amount actually protected for the spouse is either that half or the level the state has chosen to protect, whichever is higher, subject to a Federal minimum (at and below which the entire amount is protected) and maximum, $16,824 and $84,120, respectively, as of January 2000. States have the option of setting a higher minimum level but cannot exceed the Federal maximum.

Any resources not protected for the spouse are considered available to the person needing care, who is not eligible until such resources are within Medicaid eligibility limits.

Minimum and maximum amounts of both income and resources increase every year based on the cost-of-living increase as published by the Department of Health and Human Services. In addition, Federal law requires states to have administrative and judicial procedures in place that allow petitioners to seek higher protected amounts of the spouse's assets. For example, the spouse can petition for higher protected assets if the income those assets produce is needed for that person's reasonable living expenses.

Provisions Specific to Children with Disabilities

Two eligibility provisions—one mandatory, the other at states' option—were enacted specifically to serve children with disabilities. The mandatory provision relates to children—sometimes called Zebley kids—rendered no longer eligible by a 1996 change in the SSI definition of disability for children. The Zebley designation comes from a court case, upheld by the Supreme Court, contesting the 1996 change.[13] The optional provision—sometimes called the Katie Beckett or TEFRA option—allows for eligibility for a child with severe disabilities living at home, regardless of the financial circumstances of the child's parents.

Zebley Children

The welfare reform legislation of 1996 made it more difficult for children to qualify as disabled SSI beneficiaries by changing the definition of disability for children. The major impact of this change has been on children with mental disorders. In 1997, a new Federal requirement was enacted protecting Medicaid eligibility for former child beneficiaries of SSI who lost it due to this definitional change. This protection is retroactive to the original SSI change in 1996. It cannot produce actual eligibility changes, however, unless both state and family follow through and take all necessary administrative steps to get the child enrolled specifically in the state's Medicaid program. It is important to note that children who apply for SSI for the first time, and are found

ineligible for it might still qualify for Medicaid or for the Children's Health Insurance Program (CHIP) in their states, based on the family's income.

Katie Beckett Option

The Katie Beckett or TEFRA option, enacted permanently into law in 1982, enables states to provide Medicaid to certain children with disabilities living at home who need extensive care but who would, without the option, be unable to qualify because their parents' income or resource levels put them above the financial eligibility cutoff.

Before this option became available, children with disabilities were typically eligible for SSI and, thus, Medicaid only if they lived in institutional settings. This was because of deeming rules similar to those discussed above. Most state Medicaid programs followed SSI deeming rules on how income and resources are counted. Under these rules, institutionalized children were not considered part of their parents' households. Parental income and assets were therefore ignored, regardless of their magnitude. But children living with their parents *were* considered part of the parental household, making parental income and assets deemed available to the children, and substantially reducing the likelihood that children with disabilities would be eligible for Medicaid services, no matter how great the children's service needs might have been. This arrangement made it possible for children with disabilities in non-poor families to get Medicaid for institutional care but not for equivalent care provided at home.

The TEFRA option, which was enacted to create equity between the two settings in financial eligibility, is limited in the following ways. First, home care for the child must be appropriate. Second, the estimated cost of community services for the child may not exceed the cost of institutional care. Third, the child must require the level of care normally provided in an institution, making the TEFRA option unavailable for children whose disabilities do not require this level of care. In states that use the TEFRA option parents may choose either institutional or community care for their Medicaid-eligible children, subject to the above requirements.

States need to consider the following points when choosing between the TEFRA option and the HCBS waiver option for covering children with disabilities. First, states may not impose enrollment caps under the TEFRA option, as they can under the HCBS waiver option. If elected, the TEFRA option must be open to anyone who qualifies anywhere in the state. Second, states must provide to children eligible under both the TEFRA option and the HCBS waiver option the same EPSDT benefits provided to all other Medicaid children in the state. However, the HCBS option allows states to offer additional services of a non-medical nature. Finally, states may impose a share-of-cost obligation on children in an HCBS waiver program but not on children eligible under the TEFRA option.

Reducing Financial Barriers to Employment for Persons with Disabilities

Any benefit program that uses an income cutoff to determine eligibility contains a powerful disincentive for beneficiaries to work, if the earnings from that work would put them above the financial eligibility level for benefits. To the extent that Medicaid coverage is needed in order to live, the problem becomes an absolute barrier to employment rather than simply a "disincentive."

In order to preserve the incentive for persons with disabilities to work to their maximum without fear that doing so will cause them to lose their medical coverage, Federal law mandates states to disregard certain earnings amounts in determining eligibility for Medicaid. States have additional options to protect the earnings of people with disabilities who have higher earning potential.

Federal Provisions[14]

Since 1982, SSI and Medicaid have been provided for certain SSI disability beneficiaries who succeed in work and earn more than what is termed the

Substantial Gainful Activity (SGA) amount of $700 per month.[15] Such an individual will continue to receive an SSI benefit and Medicaid the same as any other SSI recipient in their state, provided their countable income is within SSI qualifying limits.[16] Individuals with earnings up to about $1100 per month are typically able to qualify under this provision while still receiving SSI cash benefits.

Former SSI beneficiaries with even higher earnings may continue to qualify for Medicaid, although they earn too much for SSI, as long as their earnings are below a state-specific level that is roughly equivalent to the value of the total SSI and Medicaid benefits they would receive if they did not work.[17] The Medicaid component of this amount is the average amount spent by Medicaid for beneficiaries with disabilities in the relevant state. States must provide Medicaid to individuals with earnings above even this level, if they can show that their medical expenses are higher than the state average used for the cutoff calculation. SSA administers both provisions, not states.

Little use was made of these protections at first because they were not widely understood. Thus, the number of working persons with disabilities whose earnings were protected in this manner in 1982, the first full year of implementation, was just under 6000. By September 1999, however, the number had risen to nearly 100,000.[18]

State Options

Advocates for persons with disabilities argue that use of the work incentive provisions has not grown even more rapidly for several reasons. First, there is an absolute cap on income for eligibility for every case (although the cap amount varies from individual to individual). Thus, however high that limit may be, there is an absolute drop-off point at which increased additional earning will result in losing Medicaid eligibility. Second, low limits on resources or assets mean that working persons with disabilities are also unable to increase their savings without jeopardizing their Medicaid eligibility. Third, receipt of SSI benefits was the gateway to receipt of medical assistance, thus making work a less viable option than dependence on public programs.

Finally, eligibility under these provisions ends if the individuals' conditions improve and they no longer meet the SSI disability criteria, even though they may still need long-term services and supports to continue to work. Congress recently addressed some of these Medicaid access problems with laws enacted in 1997 and in 1999.[19]

The 1997 provision allows states the option of expanding eligibility for persons with disabilities who have countable income from all sources up to 250 percent of the Federal poverty level—$20,875 for an individual, $42,625 for a family of four in the year 2000. These individuals need not ever have received SSI but they must, except for the level of their earnings from work, qualify for SSI.

More generously, the 1999 provision gives states the option to cover individuals with disabilities who now work without regard to their earnings from work and to raise or even eliminate eligibility limits on income from other sources or limits on assets.

States that have elected this option can also elect to continue coverage for persons eligible under that option whose disability remains severe—but whose medical condition has improved to a point that they no longer meet the usual Medicaid eligibility criteria defining disability.

A state has the option to impose a monthly premium or other cost-sharing obligations for their Medicaid benefits on these higher income persons on a sliding scale based on income. However, states choosing the 1999 option are required to charge 100 percent of the premium for those with more than annual adjusted gross income (AGI as defined for Federal income tax purposes) of $75,000.[20] The premium payment features have given rise to the term "buy-in" to describe these options.

The state, not the Social Security Administration (SSA), makes the eligibility determination for these state work incentive options.[21]

Asset/Resource Transfers: Permissions and Penalties[22]

Federal law imposes a penalty on persons who give away savings or transfer ownership of their assets for less than fair market value (termed uncompensated transfers) and who, in so doing, make their assets appear low enough to meet Medicaid's eligibility limits. States must apply this penalty to persons seeking Medicaid coverage for nursing homes, other medical institutions, and HCB waiver services under institutional eligibility rules. States have the option of applying the penalty to all persons living in the community.

The purpose is the obvious one of denying benefits to persons who could, in fact, afford to pay for those benefits with their own assets. These Medicaid rules apply to all eligibility groups in all states.[23] But individuals seeking Medicaid for payment of long-term care services, and those who work to assist them, particularly need to be aware of these rules, because the structure of the penalty makes its effects fall most heavily on such beneficiaries and their spouses, children, or survivors.

Structure of the Penalty

Both SSI and Medicaid deny benefits for persons making uncompensated asset transfers. The nature and effective duration of the penalty, however, differ between the two programs.[24] The following discussion relates to the Medicaid provisions.[25]

The general Medicaid rule is that states must determine whether an applicant, beneficiary, or someone acting on their behalf transferred assets (including the home) at any time during the 36 months prior to applying for Medicaid.[26] If the person did not receive fair market compensation, then states presume the transfer was made for the purpose of meeting Medicaid resource eligibility thresholds and qualifying for benefits. States are required to have procedures in place that allow applicants to rebut that presumption.

Permissible Transfers

Certain transfers can be made without penalty:

- Transfers made to a spouse or a third party for the spouse's benefit.
- Transfers of a home to a minor child or child with disabilities, or siblings or adult children who have lived in the home *before* the beneficiary was admitted to an institution or the waiver program, and who meet certain other conditions.[27]
- Transfers by Medicaid applicants/recipients to their blind children or children with disabilities or to a trust for those children's benefit.
- Assets transferred into a trust solely for the benefit of a person under age 65 with a disability. Eligible trusts include:
  - — *Special needs trusts* (unused portions must revert to the state on the death of the individual, up to the total Medicaid amount spent on the individual's behalf)
  - — *Pooled trusts* established by a nonprofit association that manages multiple accounts (same rule on unused portions).

These trusts are not counted in Medicaid's resource eligibility determination.

When a state has determined that an impermissible transfer has taken place, it must deny coverage for long-term care services in an institution or HCB waiver services. Coverage may also be denied at state option for such non-institutional long-term care services as home health or personal care provided outside the waiver context. Note: *Such penalties do not affect the person's eligibility to receive any other services under the state's Medicaid plan.*

The duration of the penalty is calculated by dividing the uncompensated value of the transferred assets by the monthly cost of care in a private nursing facility. The same formula is used for persons applying for HCB waiver services. Several rules reduce the practical effects of the penalty:

- The penalty period begins the month the transfer occurred, even if the transfer was

Effect of Transfer on Benefit Loss: Example

- $20,000 is withdrawn from savings and received by an adult child.
- The transfer occurs in January.
- Monthly cost of nursing facility services is $4,000.
- This makes the penalty period five months ($20,000 divided by $4,000).
- The penalty period begins in January; it therefore ends in June.
- The penalty period is the same, whether or not the person uses services and whether the needs are institutional or less costly community services.
- On the assumption that all other Medicaid eligibility criteria are met, a person who applies in January is eligible for all services except for the long-term care services. A person who waits to apply in July can receive all Medicaid services immediately, because the penalty period has already expired.

made many months before the individual applies for Medicaid. Thus, a transfer will have no practical effect if it was modest and occurred relatively early in the look-back period before the individual applies for Medicaid.

- States calculate the duration of the penalty based on nursing facility rates—whether the person who has transferred assets is actually in a nursing home or seeking home and community care—even though the monthly cost of services in the community is likely to be substantially lower.

- The penalty calculation is the same regardless of (a) whether the person was living at home or in a facility at the time of transfer and (b) whether the person was actually using or paying for services.

- States must make exceptions in cases of undue hardship.

Estate Recoveries

Federal law requires all states to recover assets from the estates of two groups of Medicaid beneficiaries after their deaths: those who were age 55 or older when they received Medicaid benefits, and those who received Medicaid nursing facility or ICF/MR benefits regardless of age. At a minimum, states must use the same definition of estate that is used for probate law in that state. They are permitted to use a broader, state-established definition that captures additional assets. States are mandated to recover any amounts they have paid on the individual's behalf for long-term care services (whether facility care under the state plan or home and community care under waiver), as well as any hospital costs and prescription drug benefits related to the condition requiring long-term care services. They also have the option of recovering all amounts spent on Medicaid benefits. But state recovery actions must be delayed if there is a surviving spouse or, in certain cases, a child or sibling living in the home. And states have the option of not recovering at all in the case of very small estates, if the cost of doing so is likely to exceed the amount that can be recovered.

Endnotes

1. The sole author of this chapter is Letty Carpenter.

2. Additional information about the Medicare program can be obtained from the Medicare Handbook (available at www.hcfa.gov).

3. Section 1902(r)(2) of the Social Security Act.

4. This limitation applies only to income and only to certain optional eligibility groups. There are no such limits on using 1902(r)(2) to liberalize rules for *resources*.

5. As described above, under Section 1902(r)(2) of the Act, a state can elect to disregard more generous amounts.

6. States can use higher levels or additional disregards under the 1902(r)(2) exception described above.

7. Typically this is every month. In some states it is every six months. But in the latter case the person must be able to spend-down an amount that equals six times their monthly "excess" income before becoming eligible.

8. State-by-state information concerning supplements for SSI beneficiaries may be found in State Assistance Programs for SSI Recipients: January 1999. (July 1999) Social Security Administration, Office of Policy, Office of Research, Evaluation, and Statistics. Available at the

SSI website (www.ssa.gov).

9. Under Section 1902(r)(2), described above.

10. Post-eligibility share-of-cost rules also apply to persons in ICFs/MR, long-term hospitals, and other medical institutions, regardless of eligibility category. Persons who become eligible by meeting a medically needy spend-down obligation also face an additional post-eligibility share-of-cost obligation based on their remaining income.

11. This differential treatment comes about because SSI treats persons living in an institution as a separate household and eligibility unit than their family members. The 209(b) states are exceptions in that they continue to deem, even for persons who live in institutions.

12. Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982.

13. The U.S. Supreme Court decision was Sullivan v. Zebley, 493 U.S. 521 (1990). The decision became moot in 1997, when Section 4913 of the Balanced Budget Act of 1996 (P.L. 105-33) restored Medicaid to the children who had lost out under SSI's earlier definitional change.

14. Sections 1619 and, equivalently, 1905(q) of the Social Security Act.

15. The Social Security Administration has published a proposed rule to adjust the SGA level automatically each year for individuals with impairments other than blindness. The adjustments would be based on any increase in the national average wage index. SSA hopes to publish the final rules in time for them to become effective in January 2001.

16. The provision, which originated as a demonstration in 1980, was fully implemented in 1982 but not made permanent until 1986 in Section 1619(a) of the Act.

17. Section 1619(b).

18. Numbers from "Quarterly Report on SSI Disabled Workers and Work Incentive Provisions," (September 1999) Social Security Administration, Office of Research, Evaluation, and Statistics.

19. The 1997 provision is in Section 4733 of the Balanced Budget Act of 1997 (P.L. 105-33). The 1999 provision is in Section 201 of the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170).

20. States are not permitted to use Section 1902(r)(2), described above, as a way to get to a higher effective income level at which full premiums are charged.

21. Additional information on the Medicaid Buy-Ins may be obtained from the HCFA website devoted to the Ticket to Work and Work Disincentive Act (TWWDA).

22. The terms "assets" and "resources" are used interchangeably here. Medicaid law on transfers refers to "assets" (which may include income), while "resources" is the more generally used eligibility term (which does not include income).

23. This includes 209(b) states.

24. If the Social Security Administration finds a person ineligible for SSI because of a transfer of resources, that person still has the right to apply for Medicaid through their state and, because of the differences in how the penalty period is calculated, is likely to qualify with a shorter penalty period.

25. The penalty for resource transfers in SSI, recently enacted in P.L. 106-169, is a loss of SSI benefits for a period of time. If the Social Security Administration finds that resources were transferred for less than fair market value in the 36 months prior to application, then a penalty period begins in the month the transfer occurred. The duration in months is calculated by dividing the amount transferred by the maximum monthly cash benefit otherwise payable.

26. The period is 60 months if assets were transferred into or out of certain trusts.

27. Social Security Act, Section 1917(c) (2) (iii) and (iv).

Annotated Bibliography

Kassner, E., and Shirey, L. (2000). ***Medicaid financial eligibility for older people: State variations in access to home and community-based waiver and nursing home services.*** **Pub. #2000-06, Washington, DC: AARP, Public Policy Institute.** (27 pages)

This report focuses on the impact that Medicaid financial eligibility rules have on access to home and community based services for older people with disabilities. While some states use the same financial criteria to determine nursing home and waiver eligibility, there are other states that use more restrictive criteria to determine waiver eligibility. The report analyzes states' treatment of income and asset rules for nursing home and waiver eligibility as well as states' treatment of the income and assets of Medicaid beneficiaries' spouses. It also discusses the maintenance needs allowances permitted by state Medicaid waiver programs serving older people and makes policy recommendations for changing eligibility rules to enable more Medicaid beneficiaries to receive home and com-

munity based services. *To obtain a free copy of this document, contact AARP's Public Policy Institute at (202) 434-3860 or search their website www.research.aarp.org.*

Schneider, A., Fennel, K., and Keenan, P. (May 1999). *Medicaid eligibility for the elderly*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured. (25 pages)

This publication is designed for both consumers and program designers. It discusses characteristics of the elderly population and Medicaid and Medicare policy regarding long-term care. It also discusses the options available to states to design their Medicaid programs. Tables and graphs help in understanding the complex eligibility process. Particularly useful for consumers is the clarification of the Medicaid eligibility "pathways" for low-income, elderly individuals. The document describes various options and how states have expanded Medicaid coverage. The document contains only a brief discussion on the provision of home and community services. *This document may be obtained free of charge from the Kaiser Family Foundation website at www.kff.org or ordered from their publications line at (800) 656-4533.*

Schneider, A., Strohmeyer, V., and Ellberger, R. (July 1999). *Medicaid eligibility for individuals with disabilities*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured. (28 pages)

This document highlights the complexities in the Medicaid program that create barriers to coverage for the population with disabilities. It focuses on four groups of individuals with disabilities as it explains the "pathways" to Medicaid eligibility. The document explains both the importance of Medicaid to low-income people with disabilities and the ways in which federal policies structure states' Medicaid eligibility options. This document makes a very complex issue understandable for both consumers and policy makers. *This document may be obtained free of charge from the Kaiser Family Foundation website at www.kff.org or ordered from their publications line at (800) 656-4533.*

Schneider, A., Fennel, K., and Long, P. (September 1998). *Medicaid eligibility for families and children.* Washington, DC: The Kaiser Family Foundation. (25 pages)

This publication reviews Medicaid eligibility policy for low-income children and nondisabled adults. It focus-

es on the complexity of Medicaid eligibility policy as a possible barrier to fully covering all children or adults who qualify. The paper summarizes state and federal policy options that may increase the number of people eligible for Medicaid, as well as enroll more of those who are eligible. *This document may be obtained free of charge from the Kaiser Family Foundation website at www.kff.org or ordered from their publications line at (800) 656-4533.*